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Incorporation by Reference

Agreement for Participation as a Primary Care Provider or Clinic in the Kentucky Patient Access and Care System (KenPAC)
May 2002 edition

MAP 357A KenPAC SSI Primary Care Provider (PCP) Change Form
October 2002 Edition

MAP 357B KenPAC Primary Care Provider (PCP) Change Form
October 2002 Edition

Department for Medicaid Services
Cabinet for Health Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Adopted: April 11, 2003

MAP 358
(10/91) (Revised 05/02)

Provider Number: _____

Commonwealth of Kentucky
Cabinet for Health Services
Department for Medicaid Services

KENTUCKY MEDICAL ASSISTANCE PROGRAM

Agreement for Participation as a Primary Care Provider or Clinic in the Kentucky Patient Access and Care System (KenPAC)

This agreement is entered into by the Cabinet for Health Services, Department for Medicaid Services, and _____
(Enter Name of Physician or Clinic)

I. General Statement of Purpose and Intent

The Cabinet for Health Services contracts with licensed physicians, licensed, certified advanced registered nurse practitioners (ARNP), licensed primary care centers, licensed rural health clinics, and physician group practices that participate in the Kentucky Medical Assistance Program (Medicaid) for the provision of primary care to specified Medicaid recipients who may select, or be assigned to, the contracting physicians; and for management of other health care needs through the appropriate referral and authorization by the physician of specified Medicaid services for assigned recipients. This agreement describes the terms and conditions under which the agreement is made and the responsibilities of the parties thereto.

II. General Statement of Law

The Kentucky Patient Access and Care (KenPAC) system is a primary care patient management system and is subject to the provisions of Kentucky Revised Statutes and Kentucky Administrative Regulations. This agreement shall be supplementary to the usual Medicaid participation agreement entered into by participating in the Medicaid Program, and all provisions of that agreement (except to the extent superseded by the specific terms of the KenPAC supplementary agreement) shall remain in full force and effect. The provider agrees to abide by all existing laws, regulations, rules, and procedures pursuant to the KenPAC program and Medicaid participation.

111. Definitions

A. "Advanced Registered Nurse Practitioner (ARNP)" as defined in defined in KRS 314.011(7).

B. "The Cabinet" means the Kentucky Cabinet for Health Services.

C. "Clinic" means a Medicaid participating clinic that is a legal entity (e.g., corporation, partnership, etc.) as shown by the possession of a federal tax identification (employer) number; for KenPAC purposes, group practices and similar arrangements which do not meet the specified requirements shall not be considered clinics.

D. "The Department" means the Kentucky Department for Medicaid Services;

E. "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

F. "Enrollee" means a Medicaid enrollee who is appropriately enrolled with a primary physician or clinic.

G. "KenPAC services" are those Medicaid services that must be provided or managed for each enrollee by the enrollee's primary physician or clinic. KenPAC services are further described in Section IV (A).

H. "Medicaid" means the Kentucky Medical Assistance Program.

I. "Other Medicaid services" are all Medicaid services other than KenPAC services.

J. "Patient management" means being responsible for the health care management of the enrollee with regard to that group of medical services within KenPAC. If not directly provided, medical services that are necessary should be arranged (through referral) or authorized by the primary physician or clinic.

K. "Physician Assistant" as defined in defined in KRS 311.550(17).

L. \'Primary Care" means the ongoing responsibility of directly providing medical care (including diagnosis and/or treatment) to an enrollee or, when necessary, referring the enrollee to another provider for diagnosis and/or treatment.

M. "Primary care provider" means a Medicaid participating physician, clinic, primary care center, rural health center, advanced **registered nurse practitioner or physician assistant practicing as a** general practitioner, family practitioner, pediatrician, internist, obstetrician, or gynecologist signing this agreement.

N. "Prudent layperson standard" means the criterion used to determine the existence of an emergency medical condition whereby a prudent layperson determines that a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the person could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

O. "Specialist" means a physician whose practice is limited to a particular branch of medicine or surgery, including one whom, by virtue of advanced training, is certified by a specialty board as qualified to so limit their practice.

P. "Urgent care" means a covered service that, while not required on an emergency basis, is required promptly to prevent substantial deterioration of a KenPAC recipient's health status and for which the failure to provide a service promptly would reasonably be anticipated to cause substantial harm to a recipient. For purposes of this definition, promptly shall mean the same day or within forty-eight (48) hours based on a medical provider assessment of urgency of need.

IV. It is agreed that the KenPAC provider shall:

A. Provide patient management for the following services: physicians' services, pharmacy services, to the extent the authorizing prescription is issued by the primary physician or clinic, hospital inpatient and outpatient services, laboratory and radiological services, ambulatory surgical center services, home health services, primary care center services, rural health clinic services, nurse anesthetist services, durable medical equipment and medical supplies, physical therapy, occupational therapy and speech therapy, and advanced registered nurse practitioner services. However, for KenPAC purposes, the physicians' services element excludes ophthalmologic, psychiatric and obstetrical services, and :routine newborn care billed under the mother's MAID number.

B. Accept enrollees pursuant to the terms of this agreement, including both voluntary and mandatory assignments.

C. Provide or arrange for primary care practitioner coverage for services, consultation, or approval of referrals twenty-four (24) hours per day, seven (7) days per week.

D. Provide primary care and patient management services to each enrollee, in accordance with the provisions of this agreement, and render necessary service pursuant to the Medicaid Program provider manual governing the provision of service in the provider's particular setting.

E. Determine the necessity for and authorize, when appropriate, non-emergency care covered under the KenPAC program.

F. Make referrals when appropriate; such referrals may be for services covered under KenPAC or for services not covered under KenPAC; the provider referred to may be another KenPAC primary care provider, or physician specialists or other providers not participating in KenPAC, but participating in Kentucky Medicaid.

G. Authorize as appropriate any follow-up consultations and/or treatment, subsequent to making a referral to a specialist for consultation and/or treatment of a specific condition, for the duration of the illness. This shall include services rendered by the specialist and referrals for related services made by the specialist.

H. Authorize, when appropriate, treatment for urgent or emergency care in accordance with KenPAC provisions relating to those services.

I. Make a referral for a second opinion if requested by the enrollee when surgery has been recommended; the KenPAC provider shall render treatment personally or through referral after the second opinion.

J. Refer the enrollee to the local health department for necessary immunizations that are not provided to enrollees by the primary care provider.

K. Maintain a unified patient medical record for each enrollee.

L. Document in the enrollee's record all authorizations for services provided by other providers that are patient managed services.

M. Review enrollee utilization and cost reports provided by the Medicaid Program, and advise the Medicaid Program of any errors, omissions or discrepancies that the provider may be aware.

N. Provide the Cabinet, the Department, the Medicaid Program, and the United States Department of Health and Human Services, or duly designated representatives of the above, access (including on-site inspections, review and copying) to all records relating to the provision of services under this agreement; the KenPAC providers shall retain such records for at least five (5) years from the date of creation or until any on-going audits have been settled, if longer.

V. It is agreed that the Department shall:

A. Pay each primary care provider a management fee of $4.00 monthly for each enrollee the primary care provider has as of the first day of each month; however, the maximum monthly fee that may be paid each primary care provider (or clinic for each full time equivalent physician position) shall not exceed $6,000 except when a waiver of the enrollee upper limit has been granted, and as provided for in Section VI (A)(1)(e) of this agreement. If a waiver has been granted with regard to the upper limit of 1,500 enrollees, a management fee of $4.00 per month shall be paid for each enrollee who is above the limit.

B. Notwithstanding the preceding (or any other provision herein) the Department shall evaluate the KenPAC system after one (1) year of program experience to determine cost effectiveness, i.e., that the system has not resulted in a net increase in program costs. If it appears at that time that KenPAC is not cost effective the enrollee management fee will be reduced by an amount sufficient to assure cost effectiveness. Providers will be notified in advance of the amount and effective date of any reduction in the management fee. If a reduction is made which empirical data subsequently shows to have been unnecessary for cost effectiveness the Department may rescind all or any part of the reduction.

C. Reimburse the primary care provider the appropriate management fee for enrollees within a reasonable period of time; this shall generally be by the tenth (10th) day of the month. Although management fees shall be paid only for enrollees who are enrolled on the first day of the month, if an enrollee is transferred on an emergency basis from one primary care provider to another, the accepting primary care provider shall perform the management service without charge for the balance of the acceptance month to preclude payment of two (2) management fees for the same enrollee in the same month.

D. Provide the primary care provider with a list of enrollees each month.

E. Utilize data relating to utilization by enrollees to determine whether primary care providers are within acceptable KenPAC practice and use patterns using the methodology in Appendix A of this agreement.

F. Refer to Appendix A for a listing of the enrollee utilization measures and the description of the methodology that will be used in determining whether primary care providers should be placed on notice, terminated and prohibited from KenPAC participation for up to one year, and relieved from notice.

G. Provide the primary care provider with appropriate reports of utilization and costs for KenPAC services at such intervals as the Department for Medicaid Services may determine appropriate; and provide to any primary care provider upon request additional information as considered appropriate relating to Medicaid utilization and expenses for their enrollees.

H. provide reimbursement for medical services of the KenPAC primary care provider in accordance with the fee for service or cost based payment methods specified by regulation for such services.

VI. General Terms and Conditions

A. Assignment of Enrollees

1. Limits on Number of Enrollees per Physician or Clinic

   a. No physician or ARNP participating individually may have assigned more than 1,500 enrollees or the number specified by the physician or ARNP, whichever is less.

   b. No clinic participating in KenPAC as a clinic (i.e., with assignments directly to the clinic) may have more than **1,500** enrollees times the number of full time equivalent primary physicians or ARNPs for the clinic or the number specified by the clinic, whichever is less, except as provided in Items c. and d., following.

   c. Primary care centers may also have **1500** enrollees times the number of full time equivalent physician assistants employed by the primary care center.

d. No rural health clinic may have assigned more than 1,500 enrollees times the number of full time equivalent primary physicians plus 1500 enrollees times the number of full time equivalent advanced registered nurse practitioners and physician assistants employed by the clinic, or the number specified by the clinic, whichever is less, except that no rural health clinic shall be required to have an upper limit of less than 1,500 enrollees.

e. The upper limits on enrollees may be waived by the Medicaid Program upon the agreement of the primary care provider to secure adequate coverage by primary care providers in medically underserved areas or when other factors (i.e., physician non-participation in KenPAC) necessitate such action.

f. Notwithstanding the upper limits on enrollees contained herein, enrollee lists shall be updated periodically for voluntary enrollees (i.e., those choices made by recipients) and, therefore, there may be some slight variance in excess of the limits previously specified. The primary care providers will be paid the usual management fee of $4.00 per enrollee when this occurs, except that in no instance shall the primary care providers be paid more than $6,000 per month for the first 1,500 enrollees.

2. Recipient Choice

a. The Medicaid Program shall permit recipients to choose from among participating primary care providers, and the primary care provider shall be required to accept enrollees who have chosen them; however, a primary care provider may secure the disenrollment of a recipient by notifying the Medicaid Program so long as prior written notice has been given to the recipient. Disenrollment will be accomplished using normal administrative procedures, so that actual disenrollment may take one (1) to two (2) months or longer in some instances. A Primary care provider must continue to provide KenPAC services to enrollees while disenrollment is being accomplished.

b. Recipients who do not choose a primary care provider will be assigned by the Department based on historical usage if appropriate, or randomly by rotating assignment as appropriate to participating primary care providers in the recipient's county of residence.

c. Recipients shall be permitted to change primary care providers upon request using established procedures.

B. Participation of Physicians and Advanced Registered Nurse **Practitioners Employed** by **Clinics**

1. Clinics and group providers shall be required to have each primary physician and advanced registered nurse practitioner employed by the clinic, who will be participating as a KenPAC primary care provider, cosign the KenPAC Physician Clinic

Agreement, whereby the employee agrees to provide KenPAC services under the terms and conditions of this agreement in its entirety; the clinic understands and agrees that no employee may function as a KenPAC provider with that clinic if such employee is not a party to the clinic agreement.

2. Clinics may choose to have enrollees assigned to the clinic, or to have enrollees assigned directly to primary physicians or ARNPs who are employed by the clinic on a full time basis; however, a clinic may not choose both methods.

C. Termination from Participation

1. All individually participating primary physicians or ARNPs must notify the Medicaid Program, in writing, thirty *(30)* days in advance of termination of KenPAC status to allow for enrollee reassignment.

2. Clinics or group providers with enrollees assigned solely to the clinic or group shall notify the Medicaid Program, in writing, within thirty (30) days whenever a physician or advanced registered nurse practitioner employee who has cosigned a KenPAC agreement leaves the employ of the clinic or group or is no longer willing to function as a primary care provider; if reassignment of enrollees is necessary due to loss of physician or advanced registered nurse practationer employees by a clinic, the clinic will be allowed up to ninety (90) days from the date of loss of the employee's services to secure additional staff, after which, reassignment will proceed as necessary in whatever manner is determined most appropriate by the Medicaid Program.

3. Clinics or group providers with primary physicians or ARNPs participating as full-time employees of the clinics or groups, and who have enrollees assigned directly to the physician or ARNP, must notify the Medicaid program, in writing, thirty (30) days in advance of termination of the primary physician's or ARNP's KenPAC status, since the recipient is not assigned to the clinic employer but to the physician or ARNP.

4. Any primary care provider terminated from KenPAC participation by the Medicaid Program for any reason shall have available any rights of review and appeal otherwise provided for by law and regulations. In addition, the provider may appeal the proposed termination directly to the Commissioner, Department for Medicaid Services within ten (10) days of the receipt of the notice of termination. The Commissioner will schedule a hearing within twenty (20) days, with such hearing to be held within thirty (30) additional days.

The provider, and his duly designated representative, including legal counsel, may present evidence to show that continued participation by the provider as a KenPAC primary care provider is appropriate, and the Commissioner will take such evidence into consideration (as appropriate) when making the decision.

The provider's KenPAC participation may continue during the process of appeal to the Commissioner, Department for Medicaid

Services so long as the provider continues to be a lawfully participating provider in the Medicaid Program, the KenPAC program is continuing, and the termination is not being made under the provisions of VI(C)(7) of this agreement.

If the Commissioner upholds the original termination decision, the provider will be notified at the time of the decision of the actual termination date. The hearing decision of the Commissioner with regard to termination from KenPAC shall be the final decision of the Cabinet.

5. This agreement terminates automatically upon the death of the primary physician or ARNP, or sale of the primary physician's or ARNP's practice, or termination of his/her status as a participating provider in the Medicaid Program.

6. This agreement terminates automatically upon the primary clinic's being sold or otherwise going out of business, or filing for bankruptcy, or being terminated from the Medicaid Program as a participating provider.

7. The Medicaid Program may terminate the agreement immediately upon written notice to the provider when such is considered necessary by the program to assure the continuance of necessary and appropriate service to Medicaid recipients.

8. Either the primary care provider or the Medicaid Program may terminate this agreement upon thirty (30) days written notice to the other party except as stated in VI(C)(7), above; however, a KenPAC primary physician or clinic may terminate participation effective only on the first day of the month.

D. Miscellaneous Provisions

1. Primary care providers must transfer the KenPAC recipient's medical record to the receiving primary care provider upon a change of primary care provider by a recipient who remains eligible for Medical Assistance and continues (or renews) KenPAC participation, when the medical record is requested in writing by the new primary care provider and the request is agreed to by the recipient.

2. Primary care providers shall not utilize discriminatory practices with regard to enrollees such as separate waiting rooms, separate appointment days, or preference to private pay patients.

3. Recipients may be removed from KenPAC and assigned to the Medicaid Program's lock-in program if a pattern of program abuse is identified.

4. This agreement may not be transferred.

VII. Selection of Options (Select Appropriate Option)

A. Individual Physicians or Advanced Registered Nurse Practitioners

☐ I am an individual physician or ARNP electing to participate as such in KenPAC. My practice specialty is _____ (general practice, family practice, pediatrics, internal medicine, obstetrics/gynecology). I agree to accept _____ enrollees. Following are the sites in which I practice and the desired number of enrollees for each site (the sum of enrollees by site may not exceed, in total, the number the physician or ARNP has agreed to accept):

Site Name	County Name
Address	county Code
Address	#Enrollees
Telephone No.	Exceed Quota?
Site Name	County Name
Address	county Code
Address	#Enrollees
Telephone No.	Exceed Quota?
Site Name	County Name
Address	county Code
Address	#Enrollees
Telephone No.	Exceed Quota?

B. Clinics with Direct Assignment of Enrollees to the Clinic

☐ I am an authorized representative of a clinic with _____ full-time equivalent physicians and _____ full-time equivalent advanced registered nurse practitioners. My federal tax identification (employer) number is _____. I agree on behalf of the clinic to accept _____ enrollees. Each primary physician or advanced registered nurse practitioner employee who will be participating in the KenPAC program will cosign this agreement and thereby be made a party to it. My clinic's practice specialty is _____ (general practice, family practice, pediatrics, internal medicine, or obstetrics/gynecology); I certify that the clinic has at least one (1) full-time equivalent physician employee in this primary care area on the clinic's staff, and agree on behalf of the clinic to notify the Medicaid Program in the event this should cease to be true. Following is the name(s) of the site(s) in which the clinic's physicians practice and the desired number of enrollees for each site (the sum of enrollees by site may not exceed, in total, the number the clinic has agreed to accept):

C.

☐ I am an authorized representative of a primary care center or rural health clinic with _____ full-time equivalent physicians, _____ full-time equivalent advanced registered nurse practitioners and _____ full-time equivalent physician assistants. My federal tax identification (employer) number is _____. I agree on behalf of the clinic to accept _____ enrollees. Each primary physician, advanced registered nurse practitioner or physician assistant employee who will be participating in the KenPAC program shall cosign this agreement and thereby be made a party to it. I certify that the clinic has at least one (1) full-time equivalent physician employee in the primary care area on the clinic's staff, and agree on behalf of the clinic to notify the Medicaid Program in the event this should cease to be true. Following is the name(s) of the site(s) in which the clinic's physicians practice and the desired number of enrollees for each site (the sum of enrollees by site may not exceed, in total, the number the clinic has agreed to accept):

Site Name	County Name
Address	County Code
Address	#Enrollees
Telephone No.	Exceed Quota?

Site Name	County Name
Address	County Code
Address	#Enrollees
Telephone No.	Exceed Quota?

Site Name	County Name
Address	County Code
Address	#Enrollees
Telephone No.	Exceed Quota?

Site Name	County Name
Address	county Code
Address	#Enrollees
Telephone No.	Exceed Quota?

VIII. Enrollee Access Telephone Number (One telephone number only)

My enrollee access telephone number for **24** hours per day, 7 days per week KenPAC coverage is ( ) - and I understand this number will be printed on the Medicaid ID card of my (or my clinic's) enrollees. See Section VII to complete this information for multiple sites with different **24** hour access telephone numbers.

IX. Effective Date And Duration

This agreement shall become effective on _____ and remain in effect until amended or terminated pursuant to the terms of the agreement.

X. Signatories

KenPAC Provider Signature:

Name: _____

Title: _____

Date: _____

(Signature of Authorized Official)

Typed Name: _____

Kentucky Medicaid Provider Number: _____

Mailing Address:

_____

_____

_____

Department for Medicaid Services Signature:

Name: _____

Title: _____

Date: _____

ADDENDUM A MUST BE COMPLETED FOR ALL CLINICS.

MAP-358-A
(10/89) (Revised 01/02)

Addendum A: KMAP Agreement for Participation in KenPAC (For Clinic Use Only)

Instruction Sheet

Purpose: Addendum A is to be used as the portion of the clinic's KenPAC participation agreement which provides relevant data on employees of the clinic who will be providing primary care services.

General Instructions: Please make a copy of completed application, Parts I, II, and III and send original completed application to: UNISYS Corporation, PO Box 2110, Frankfort, KY 40602-2110.

Detailed Instructions:

1. Type in identifying information (clinic name and provider number) in Item I.
2. For Item II, the authorized official of the clinic must sign the form after completion of the listing of physicians in Item III, and insert the date of signature. The official's typed name must also be entered.
3. Item III must be completed with regard to each clinic employee who will be providing primary care services under KenPAC as an employee of the clinic. The name, degree, and provider number must be typed in; all other items except the signature may be typed in. The employee's signature may be in any form customarily used by the employee but the signature may not be rubber-stamped or delegated.

   For clinics participating as other than primary care centers or rural health clinics, the listing should contain only the appropriate data elements for physicians employed by the clinic.

   For clinics participating as primary care centers or rural health clinics, the listing should include appropriate data for the clinic medical director, physician employees (if any), nurse practitioner employees, and physician assistant employees.

Detailed Explanation of Data Elements and Instructions for Completion of III (Note: If a data element is not applicable, please enter N/A.):

1. Typed Name, degree, and KMAP provider number. (For Example: J.M. Jones, MD)
2. Quota (if assignments will be made directly to the physician(s) employed full-time by the clinic).
3. Hours employed by clinic each week. (Forty hours or above per week will be considered full time; do not include hours worked as a specialist since these cannot be considered when computing the clinic's quota or in making direct assignments.)
4. Primary care area(s). (Must be one or more of the following: general practice, family practice, pediatrics, internal medicine, obstetrics, or gynecology. These may be abbreviated in the usual way, e.g., GP, FP, etc.)
5. Location. (Actual practice site when clinic has multiple locations. If an employee works at two (2) or more locations, the number of hours worked at each location must also be shown.)
6. Signature of employee.
7. Date signed by physician.

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(10/89) (Revised 01/02)

Addendum A: KMAP Agreement for Participation in KenPAC (For Clinic Use Only)

I. This Addendum is for _____ (name of clinic).

The clinic provider number is _____

11. **I** am the authorized official for this clinic and certify that each employee of the clinic who will be providing primary care provider services under KenPAC has perscnally signed this agreement.

_____
Signature of Authorized Official

_____
Typed Name

_____
Date

111. The following is the listing of employees of the clinic who will provide primary care provider services, with each employee's actual signature. Other data has been provided as appropriate for each element.

(Data Elements: A. Typed Name, Degree, Provider Number; B. Quota; C. Weekly Hours; D. Primary Care Area; E. Location; F. Signature; G. Date Signed.)

A._____ B. _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

F._____ ***G.***_____
Signature Date Signed

_____ _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

_____ _____
Signature Date Signed

A._____ **B.** _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

F._____ ***G.***_____
Signature Date Signed

Addendum A: KMAP Agreement for Participation in KenPAC (For Clinic Use Only)

(Data Elements: A. Typed Name, Degree, Provider Number; B. Quota; C. Weekly Hours; D. Primary Care Area; E. Location; F. Signature; G. Date Signed.)

A._____ B. _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

F._____ G. _____
Signature Date Signed

A._____ B. _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

_____ _____
Signature Date Signed

A._____ B. _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

F._____ G. _____
Signature Date Signed

_____ _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

F._____ G. _____
Signature Date Signed

A._____ B. _____
Name, Degree, and Provider Number Quota

C._____ D._____ E. _____
Weekly Hours Primary Care Location Location

F._____ G. _____
Signature Date Signed

(Add additional pages as necessary)

Appendix A

KenPAC
UTILIZATION REVIEW SYSTEM
(KURS)

I. SYSTEM OVERVIEW

The KenPAC Utilization Review System (KURS) monitors services received by KenPAC enrollees and provides feedback to KenPAC patient managers pertaining to the overall utilization patterns of their KenPAC caseloads. Reports which allow patient managers to compare their caseload experiences are distributed to providers on a monthly basis. These reports provide a basis for evaluation of the performance of individual patient managers and the KenPAC system.

The system stratifies the data according to the major groups of KenPAC participating providers (i.e. general/family practice, internal medicine, pediatrics, obstetrics/gynecology, primary care/rural health and large physician clinics). Large clinics are defined as those with 3,000 or more enrollees. Such data is expressed in terms of utilization rates for seven selected variables. These rates are developed for each participating provider, for each participating specialty group, and for all KenPAC providers combined.

Providers whose individual rate for any variable falls more than +2 standard deviations from the statewide rate are provided with detailed utilization data pertaining to services received by each of the KenPAC recipients affecting this variable. Detailed utilization reports are used by the Program staff in conjunction with other available systems data to determine unacceptable practice patterns and to take appropriate corrective action.

II. DETAILED SYSTEM DESCRIPTION

The system generates measures of utilization based on dates of service. These measures are recorded monthly and converted to rates based upon each patient manager's assigned caseload during the study month.'

A. VARIABLE DESCRIPTIONS

Following are the seven measures which are used in the system:

1. Emergency room visits authorized by each participating KenPAC provider. (ER visits/100 enrollees)

2. Physician specialist referrals authorized by each KenPAC provider. (Referrals/100 enrollees)

3. Admissions to inpatient hospitals authorized by each KenPAC provider. (Admissions/100 enrollees)

4. Number of laboratory procedures authorized by each KenPAC provider. (Laboratory procedures/100 enrollees)

5. Prescriptions filled for a KenPAC provider's recipients. (Prescriptions/100 enrollees)

6. Office visits billed by each KenPAC provider for his/her own enrolled KenPAC patients. (Office visits/100 enrollees)

7. Medicaid expenditures for all services billed or authorized by the KenPAC provider for his/her own enrolled patients. (Average cost/enrollee)

8. FEEDBACK REPORTING

All participating KenPAC providers are given monthly reports (see KenPAC Report 1) which present their individual rates for the seven utilization measures in comparison to the corresponding rates for the six provider specialty groupings and the statewide rates. This report also indicates the percentile of the statewide KenPAC provider population into which each KenPAC provider's individual rates fall.

KenPAC providers also periodically receive a series of frequency distribution tables (see KenPAC Report 2 series) which array the rates of all KenPAC providers for each measurable variable according to the specialties in which they practice and on a statewide basis. These frequency distribution tables identify the median rates for all groups and all measured variables. The cost/recipient variable is not currently included in this report., but may be added at a future date.

Periodically, graphs depicting the change in individual and group rates over specific time frames are distributed to each participating provider. By considering these graphs and KenPAC Report 1, each provider is able to determine how data relating to his/her KenPAC practice compares to that of his/her peers.

Providers with rates which fall greater than ±2, il, and less than ±1 standard deviations from the statewide rate for any variable are identified by the system. The statewide rate is determined by dividing the total number of units by the total number of KenPAC enrollees, and is expressed in terms of a rate per 100 enrollees except in the case of the cost variable which is expressed per enrollee. Those providers who have rates greater than +2 standard deviations from the statewide rates are routinely sent detailed reports (see KenPAC Report 3 series) which list the recipients, billing providers and dates of service used to compute the greater than +2 standard deviations rate(s). Providers who consistently have rates which are greater than +1 standard deviation periodically receive notice that they are at the threshold of acceptability.

In addition to the above, when the KenPAC staff determines it necessary, or upon request, KenPAC providers are given a periodic report (see KenPAC Report 4) which lists all providers who have used the KenPAC referral authorization number to bill and be paid by Medicaid. This report also includes the names of the recipients for whom such referrals are billed and the appropriate dates of service. .

111. MONITORING AND ANALYSIS

The KenPAC staff reviews all monthly and periodic utilization report!; to determine individual and statewide patterns. Particular attention is given to analysis of the data for providers who fall ±2 standard deviations from the statewide rate for any variable. A cumulative weighted scoring system identifies providers who consistently fall outside acceptable thresholds of utilization. Measured services with their assigned weighted values are as follows:

Variable	Weighted Score
ER visits	1.5
Physician Referrals	1.0
Hospital Admissions	1.5
Lab Procedures	1.0
Pharmacy Services	.5
Office Visits	1.0
Average Cost	0.0

The average cost variable has no weight assigned because it is newly identified. When sufficient historical data becomes available a weighted score may be established for this statistic.

Providers whose monthly rate for any given variable exceeds ±2 standard deviations *of* the statewide rate are assigned the appropriate weighted score for that variable. Providers not exceeding the ±2 standard deviations threshold receive a score of zero. Exceeding ±2 standard deviations for more than one variable, and/or for more than one month, results in a cumulative weighted score. For example, excessive ER rates in January and February combined with excessive Office Visit rates in March and June would yield a six months cumulative weighted score of 5.0.

A provider who has a cumulative weighted score of 7.0 or higher during a six month period may be placed on probation for six months. If that provider, during the probation period, again exceeds the maximum permissible cumulative score, he/she may be administratively removed from the Program for one year. After one year he/she may be allowed to rejoin the Program on a probationary basis.

Only providers with 50 or more assigned enrollees are evaluated under the weighted scoring system. This is done to narrow the review efforts to those providers managing the vast majority of recipients (86%) and because providers with a low number of enrollees are subject to extreme

fluctuations in their utilization rates. This phenomenon makes it extremely difficult to accurately evaluate their short-term case management performance. However, providers with a low number of assigned recipients will be monitored on an annual basis. If these providers manifest unacceptable treatment and referral patterns appropriate corrective action up to, and including, expulsion from the program may be taken.

On a monthly basis, providers are notified when their rate(s) fall(s) outside the ±2 standard deviations threshold and are given an opportunity to submit an individual explanation or analysis. The KenPAC Detail Reports (KenPAC Report 3 series) in conjunction with available MMIS historical claims file data, KenPAC correspondence files, KenPAC records and on-site medical record audits, when warranted, are possible tools to determine the specific causes for abnormally high or low rates. Information gained from such analyses may permit adjustments of rates which appear misrepresentative.

The KenPAC Program also periodically uses information available from Medicaid's Surveillance and Utilization Review System (SURS), Drug Utilization Review System (DURS) and the Claims Payment System to enhance its investigations of provider utilization patterns and, when warranted, to provide feedback to the provider and, in some cases, the recipient with regard to inappropriate usage and treatment practices.

KenPAC Report 1

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES
KENPAC UTILIZATION DATA

(MONTH) (YEAR)

PROVIDER/ SPECIALTY	(Per 100 Enrollees) E.R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS	AVG COST PER ENRL
PERCENTILE							
GENERAL AND FAMILY PRACTICE							
INTERNAL MEDICINE							
PEDIATRICS							
OB/GYN							
PRIMARY CARE [illegible] HEALTH							
LARGE CLINIC (3000 + ENROLLEES)							
KENPAC							
STATEWIDE							

1/ BASED ON THE TOTAL NUMBER OF EMERGENCY ROOM VISITS BILLED USING THE PATIENT MANAGER'S AUTHORIZATION.

2/ BASED ON REFERRALS TO OTHER PHYSICIANS USING PATIENT MANAGER'S AUTHORIZATION NUMBER.

3/ BASED ON THE TOTAL NUMBER OF ADMISSIONS USING PATIENT MANAGER's AUTHORIZATION.

4/ BASED ON THE TOTAL NUMBER OF LABORATORY PROCEDURES PERFORMED USING THE PATIENT MANAGER'S AUTHORIZATION.

5/ BASED ON THE TOTAL NUMBER OF PRESCRIPTIONS PAID.

6/ BASED ON PROCEDURE CODES 90000-90080 and 90750-90778 BILLED BY PATIENT MANAGERS FOR THEIR ASSIGNED KENPAC PATIENTS.

7/ BASED ON TOTAL PAID CLAIMS BILLED OR AUTHORIZED BY PATIENT MANAGERS AND CONVERTED TO AN AVERAGE MEDICAID EXPENDITURE PER EACH ASSIGNED RECIPIENT.

KenPAC Report 2.0

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

KENPAC PRIMARY PROVIDERS STATEWIDE

DISTRIBUTION OF ____ KenPAC PROVIDERS

UTILIZATION PER 100 ENROLLEES	E. R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
<1						
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31-35						
36-40						
41-45						
46-50						
51-55						
56-60						
61-65						
66-70						
71-75						
76-80						
81-85						
86-90						
91-95						
96-100						
>100						
MEDIAN RATE						

KenPAC Report 2.1

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

GENERAL PRACTICE/FAMILY PRACTICE

DISTRIBUTION OF ____ KenPAC PROVIDERS

UTILIZATION PER 100 ENROLLEES	E. R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
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41-45						
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56-60						
61-65						
66-70						
71-75						
76-80						
81-85						
86-90						
91-95						
9 100						
>100						

MEDIA!! RATE

KenPAC Report 2.2

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

INTERNAL MEDICINE

DISTRIBUTION OF ____ KenPAC 'PROVIDERS

UTILIZATION PER 100 ENROLLEES	E.R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
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56-60						
61-65						
66-70						
71-75						
76-80						
81-85						
86-90						
91-95						
96-100						
>100						
MEDIAN RATE						

KenPAC Report 2.3

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

PEDIATRICS

DISTRIBUTION OF ____ KenPAC PROVIDERS

UTILIZATION PER 100 ENROLLEES	E. R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
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76-80						
81-85						
86-90						
91-95						
96-100						
>100						
MEDIAN RATE						

KenPAC Report 2.4

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

OB/GYN

DISTRIBUTION OF ____ KenPAC PROVIDERS

UTILIZATION PER 100 ENROLLEES	E.R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
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86-90						
91-95						
96-100						
7100						
MEDIAN RATE						

KenPAC Report 2.5

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

PRIMARY CARE/RURAL HEALTH

DISTRIBUTION OF ____ KenPAC PROVIDERS

UTILIZATION PER 100 ENROLLEES	E.R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
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,100						

MEDIAN RATE

KenPAC Report 2.6

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES

(MONTH) (YEAR)

LARGE CLINICS

DISTRIBUTION OF ____ KenPAC PROVIDERS

UTILIZATION PER 100 ENROLLEES	E.R. VISITS	PHYSICIAN REFERRALS	HOSPITAL ADMISSIONS	LAB SERVICES	PHARMACY SERVICES	OFFICE VISITS
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81-85						
86-90						
91-95						
96-100						
,100						
MEDIAN RATE						

KenPAC Report 3.1

KENPAC UTILIZATION

EMERGENCY ROOM UTILIZERS

MONTH

PROVIDER NAME _____

PROVIDER NUMBER _____

RECIPIENTS	MAID NUMBER	PROVIDER	DATE

KenPAC Report 3.2

KENPAC UTILIZATION

UTILIZERS OF REFERRED PHYSICIANS

MONTH

PROVIDER NAME _____

PROVIDER NUMBER _____

RECIPIENTS	MAID NUMBER	PROVIDER	DATE	UNITS

KenPAC Report 3.3

KENPAC UTILIZATION

INPATIENT HOSPITAL UTILIZERS

MONTH

PROVIDER NAME _____

PROVIDER NUMBER _____

RECIPIENTS	MAID NUMBER	PROVIDER	DATE

KenPAC Report 3.4

KENPAC UTILIZATION

LABORATORY SERVICE UTILIZERS

MONTH

PROVIDER NAME _____

PROVIDER NUMBER _____

RECIPIENTS	MAID NUMBER	PROVIDER	DATE

KenPAC Report 3.5

KENPAC UTILIZATION

PRESCRIPTION DRUG UTILIZERS

MONTH

PROVIDER NAME _____

PROVIDER NUMBER _____

RECIPIENTS	MAID NUMBER	PROVIDER	DATE

KenPAC Report 3.6

KENPAC UTILIZATION

PHYSICIAN OFFICE UTILIZERS

MONTH

PROVIDER NAME _____

PROVIDER NUMBER _____

RECIPIENTS	MAID NUMBER	PROVIDER	DATE	UNITS

KENPAC SSI PRIMARY CARE PROVIDER (PCP) CHANGE FORM

THIS SECTION TO BE COMPLETED BY MEDICAID ONLY:

Recipient Name_____ Recipient Phone _____ SSN _____

Address_____ City, State, Zip_____

Current Provider ID _____ Current Site Code _____ Date _____

New Provider ID _____ New Site Code _____ Quota: Open / Closed

New Provider Address _____ City, State, Zip _____

THIS SECTION TO BE COMPLETED BY RECIPIENT ONLY:

Please mail to:

Department for Medicaid Services
Care Coordination Branch, 6E-C
275 East Main Street
Frankfort, KY 40621

I am requesting a provider change for _____ (Recipient Name)

I am requesting this change because: _____

_____

_____

_____

_____

_____

This request will require prior approval from the Department for Medicaid Services (DMS) before a change will be made in your PCP.

_____ _____
Recipient's Signature Date

THIS SECTION FOR MEDICAID USE ONLY:

Approved _____ By _____ Date _____

Comments_____

_____

KENPAC PRIMARY CARE PROVIDER (PCP) CHANGE FORM

THIS SECTION TO BE COMPLETED BY WORKER ONLY:

Case Name _____ Case Number _____ Date _____

Address _____ City, State, Zip _____

Worker _____ Worker phone _____ Client Phone _____

Current Provider ID _____ Current Site Code _____

New Provider ID _____ New Site Code _____ Quota: Open / Closed

New Provider Address _____ City, State, Zip _____

THIS SECTION TO BE COMPLETED BY CLIENT ONLY:

Please complete with your worker, or mail to:

Department for Medicaid Services
Care Coordination Branch, 6E-C
275 East Main Street
Frankfort, KY 40621

I am requesting a provider change for _____ (Client Name)

I am requesting this change because: _____

_____

_____

_____

_____

This request will require prior approval from the Department for Medicaid Services (DMS) before a change will be made in your PCP. I understand that I have the right to receive fair and impartial treatment from my worker regardless of age, sex, race, religious beliefs, political affiliation, national origin, or disability.

_____ _____
Client's Signature Date

THIS SECTION FOR MEDICAID USE ONLY:

Approved _____ By _____ Date _____

Comments _____

_____

_____